*Report on Ambulances*

The Committee has considered the following three questions with reference to the ambulance problem of this city:

1. Is the practice on the part of ambulance surgeons of private hospitals to transport a certain proportion of cases to municipal hospitals to be considered prejudicial to the health and life of these patients?
2. Is the tendency on the part of private hospitals to give up ambulance districts detrimental to the teaching of traumatic surgery?
3. Should ambulance work be carried on entirely by the city, and, if so, what is the best method of organizing it?

I

The Committee studied the records of three hundred and seventeen cases which were transported in Brooklyn to the municipal hospitals during the first six months of 1926. With two possible exceptions, no hazard to the life of the patient was involved in the removal to a more distant hospital. In the opinion of the Committee, the only conditions which require the taking of the patient to the nearest hospital are acute hemorrhage, gun-shot or stab wounds of the abdomen, and conditions requiring tracheotomy.

There are many reasons for the ambulance surgeon transporting the patient to a municipal hospital. First of all, he is under instructions not to bring to the hospital certain types of cases, such as alcoholism, drug addiction, communicable diseases, erysipelas, and so on. Secondly, the ambulance surgeon is compelled to take the patient to another hospital because of a lack of beds in his own. Thirdly, the ambulance surgeon knows that certain hospitals are especially equipped for the care of certain conditions.

In examining the list of conditions of the ambulance patients who were transported to municipal hospitals, there were several instances where, in the opinion of the Committee, it was more advantageous to the patient to be taken to a large municipal hospital with adequate resources rather than to a small private hospital inadequately equipped.

In connection with the gun-shot wounds, it must be remembered that in many instances the patient is a prisoner and it is extremely inconvenient to take such a patient to a private hospital where there exist no special prison wards.

To summarize this first question under consideration, it is the judgment of the Committee that on the basis of the evidence submitted there was no malpractice in the direct transportation of these cases to municipal hospitals and that the patients were not subjected to any extra hazard on account of it.

## II

A large number of people when falling ill or when injured in the city streets are taken by taxicabs to the nearest hospital where they are almost invariably admitted whenever vacant beds are available. In view of these conditions, practically every hospital has opportunities to treat traumatic injuries. The interne staff of every hospital in the city has opportunity for experience in this type of surgery whether or not it is a hospital which operates an ambulance. The Committee feels that no hospital should be urged to maintain an ambulance service because of the opportunity it affords for the training of the surgical staff in traumatic surgery.

## III

It is evident, in so far as ambulance service is concerned, that the trend of evolution is to give up ambulance work on the part of private hospitals. The few that still maintain ambulance service do so chiefly for traditional reasons. It is the opinion of the Committee that in the not very far distant future most of the ambulance work will have to be carried on by the municipality. In view of that, it is the opinion of the Committee that the matter should be given consideration by the ciy authorities as how best to organize the municipal ambulance service system. In some American cities the entire ambulance work is done by the city under the auspices of the police department. This might, perhaps, be considered in New York City. Different districts might be assigned to each tax-exempt hospital for a certain number of cases. Information regarding available beds could

be kept in each police precinct and the patients taken to the nearest hospital where facilities were known to be available.

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## THE LIBRARY AND ITS NEW FEATURES

The Library has now been in its new quarters for more than three months and gradually it is beginning to run more smoothly. It seems a good opportunity to tell the Fellows and other readers what changes have had to be made to meet the new conditions and what increased benefits can be enjoyed in the new building.

### *Lobby*

On entering the library from the elevator, bags and papers may be left at the attendant's desk and reclaimed on leaving. At the far (east) end of the lobby, beyond the delivery desk, are the two card catalogues plainly marked "Authors" and "Subjects" and on shelves above and below the catalogue drawers are placed two complete sets of the *Index Catalogue of the Surgeon General's Library,* of the *Index Medicus,* and the *Quarterly Cumulative Index. The Reference Handbook of Medical Sciences,* the new dictionaries, the *Who's Who,* the latest editions of dictionaries of English and other languages, and the most recent medical dictionaries are also there. Boxes of call-slips used in ordering books from the stacks are also on the tables. Readers are requested to replace the catalogue drawers or books which they consult in the lobby.

### *Reading Room*

This has six tables and seats for one hundred and eight readers. Ranged clockwise around the walls of the room, commencing just to the right of the door opposite the delivery desk, are the bound periodicals for about the last five years. Some have asked why we do not have in this room the last five years of every medical magazine. The answer is that of those periodicals for which there is great demand we have placed volumes for perhaps ten or fifteen years. Such magazines are the *Journal of American Medical Association,* the *British Medical Journal, The*